Guy's and St Thomas' NHS
NHS Foundation Trust

Office of the Chief Executive
Gassiot House
St Thomas' Hospital
Westminster Bridge Road
London SE1 7EH

Rachel Redman HM Coroner
Central and South East Kent
Elphicks Farmhouse
Hunton
Kent
ME15 0SB

By email CSEKCoroner@kent.gov.uk and post

Our ref: 730

29 April 2016

Dear Madam,

Re: Kevin John Gilbert deceased

I write in response to your report to prevent future deaths made under regulation 28 of the Coroners (Investigations) Regulations 2013 following the inquest into the death of Mr Gilbert on 2 December 2015. First I must apologise for the delay in this letter being sent to you, there has been an administrative failure in the Trust which meant that your letter did not get handled as it should have been, please accept my apologies for this, no discourtesy to the Court was intended and the failure is being investigated so that I can be assured it will not happen again.

At inquest you concluded that Mr Gilbert died of natural causes, the cause of death was:

1a Acute haemopericardium;
1b Aortic dissection

During the course of the inquest you heard evidence that gave you cause to be concerned that there was a risk of future deaths unless action was taken. You were concerned that there was delay in Mr Gilbert being transferred to St Thomas' Hospital because the SpR taking the phone referral seemed to be unclear that such referrals must be discussed immediately with the duty consultant. As a result the SpR who took the referral asked for the CT imagery to be made available before accepting the patient and did not escalate the decision to a consultant. This meant that Mr Gilbert waited three hours before being transferred.

You heard evidence from Mr Young, consultant cardiothoracic surgeon that the practice of the department at the time was that any such emergency referrals must be discussed immediately with the duty consultant, this is because the presentation of patients with a dissection can vary widely and the plan for transfer is particular to each patient. There was no policy that required CT scans to be available before a decision to transfer was made, this was a decision that could only be made by a consultant.

Action to be taken

You have asked that all appropriate action is taken to ensure that junior clinical staff are aware that such emergencies must be discussed immediately with a consultant.

Action taken

In January 2015, shortly after Mr Gilbert died, the referring consultant wrote to Mr Avlontis, consultant cardiothoracic surgeon and raised concerns about the delay in transfer. Following receipt of the letter Mr Avlonitis wrote to all registrars in the Cardiothoracic Department to clarify the department's process for accepting dissection referrals. He confirmed that all such referrals must be discussed immediately with the duty consultant and any decision to ask to review CT imagery before transfer could only be made by a consultant. The text of the email is shown below.

"Dear Registrars

There has been a dissection death recently before transferring a patient from the referring hospital to St. Thomas'. During the investigation process, it has come to light that there may be confusion amongst some of you with regards to the process of accepting dissection referrals. I am writing to clarify the process.

1) When a Registrar receives a referral of an aortic dissection, that Registrar needs to inform the on-call Consultant Cardiac Surgeon as soon as possible. It is up to the Consultant to decide the timing of transfer. Delay in informing the Consultant may result in delay in transferring the patient.

2) There is no departmental policy to transfer the CT scan for viewing before a decision for patient transfer is made. It may be that in some particular cases, the CT scan images need to viewed before the decision to transfer the patient is made. However, such decision to delay transfer can only be taken by the Consultant based on clinical grounds and not by the Registrar. In the majority of cases, after discussion with the on-call Consultant Cardiac Surgeon, transfer of the patient will be requested immediately and in parallel with transferring the scans."

The Trust is absolutely committed to learning from incidents and about how care can be improved and delivered more effectively. I am confident that following the email, and the reinforcement of the message by consultant staff, that all junior staff are completely clear that dissection referrals must be reviewed immediately by the duty consultant and they understand that the transfer decision must be made by a consultant.

I would also like to make the Coroner aware of a more recent change to the management of dissection referrals at the Trust. It has always been the case that there is an 'open door' policy for leaking abdominal aortic aneurysms, meaning they are accepted by the vascular surgical team for immediate transfer if clinically appropriate, with a guarantee that theatre and critical care capacity will be made available. This approach has now been extended to include dissections of the ascending aorta and arch such as suffered by Mr Gilbert. Therefore, from May 2016, any such referral to this Trust will be discussed immediately with the duty consultant cardiac surgeon (as outlined above), who will then be able to authorise immediate transfer if clinically indicated, with that same guarantee that theatre and critical care capacity will be made available. Taken together, these two measures assure me that there should be no possibility of the confusion that led to the delay in transferring Mr Gilbert recurring, and that patients with aortic dissections can be assured of receiving the rapid access to the Trust's services that their condition warrants.

Yours sincerely,

Amanda Pritchard

Amanda Pritchard
Chief Executive